MANAGED CARE
ANNUAL STATISTICAL REPORT

Published April 1999

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The Managed Care Annual Statistical Report provides information about the managed care programs rendering care to Medi-Cal beneficiaries. It provides information on the number of persons enrolled in managed care, and a description of some of the demographic and eligibility characteristics of this population.

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MANAGED CARE ANNUAL STATISTICAL REPORT

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Introduction

The Managed Care Annual Statistical Report provides information about the medical managed care programs rendering care to Medi-Cal eligibles. It provides information on the number of persons enrolled in managed care and a description of some of the demographic and eligibility characteristics of this population.[1]

The Managed Care Annual Statistical Report does not provide cost or utilization information for the Medi-Cal managed care population. Cost data for this population as well as those in fee-for-service are available in the Annual Statistical Report issued by this Section. Managed care utilization information is currently limited but may become available at a future date from the State Department of Health Services (DHS). Detailed information about dental managed care can be obtained from the DHS Payment Systems Division, Office of Medi-Cal Dental Services.

This report is comprised of three Sections, each of which describe the managed care program and its population in the broader context of the whole medical Medi-Cal program. These Sections are: 1) current enrollment data; 2) demographic characteristics; and, 3) eligibility continuity and rate of new eligibles.

A description of the history and types of managed care contracts is available in the Managed Care Annual Statistical Report published in March 1998. This report is available on the Internet at http://www.dhs.ca.gov/MCSS/. As indicated in that report, some managed care contract capitation rates are publicly available; these can be found on the Internet at http://www.dhs.ca.gov/mcs/mcmcd/.

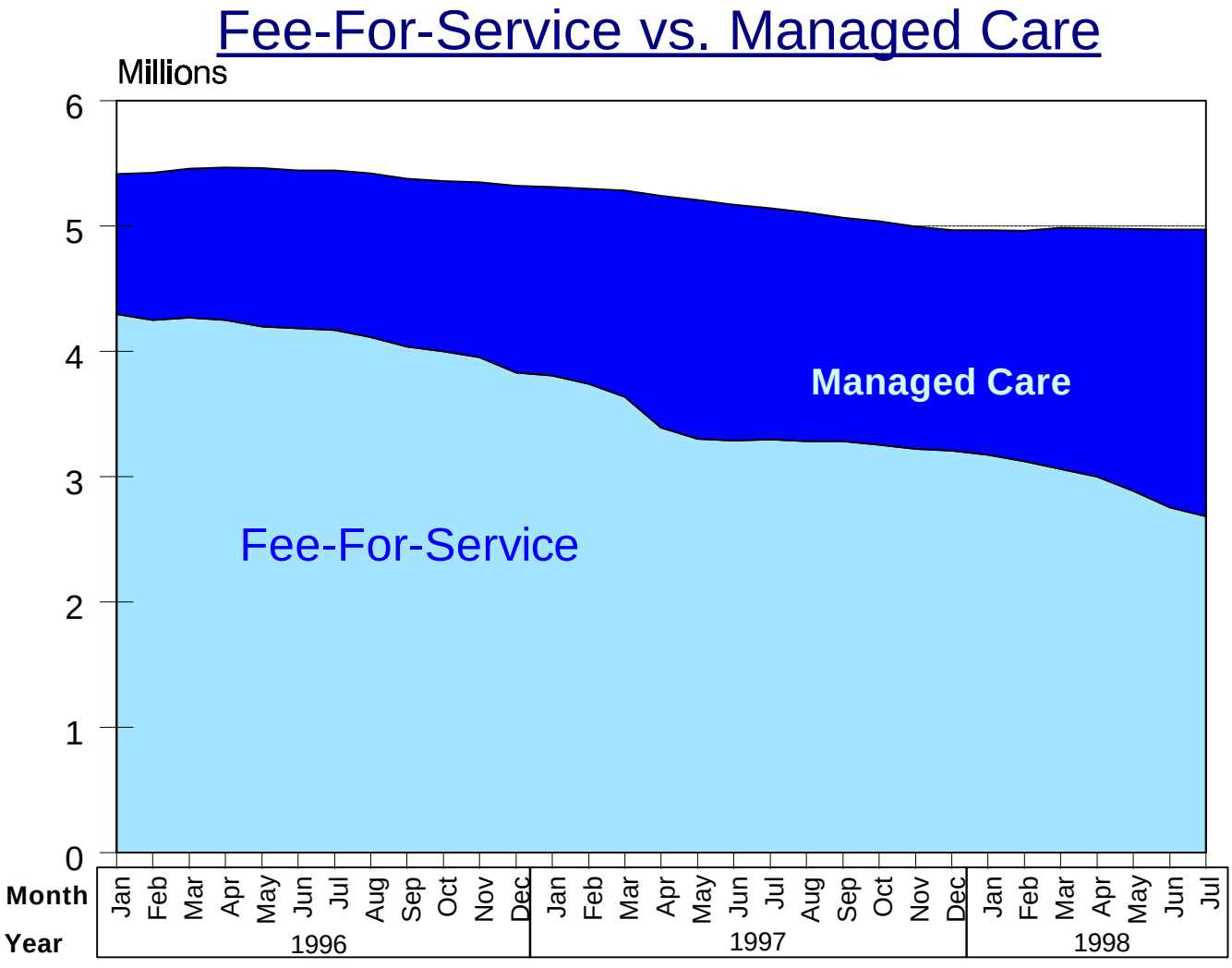
[1] The terms "eligible," "beneficiary," and "enrollee" are used interchangeably within Medi-Cal. Each refers to a person who meets all requirements for receiving a Medi-Cal medical service or good (e.g., drugs, DME items) and is enrolled in the Medi-Cal program. These terms are in contrast to the term "user," who instead is an eligible/beneficiary/enrollee actually using a service or receiving a drug, DME item, etc.

Section 1, Current Enrollment Data

Tables 1.1A, Medi-Cal Eligibles by Program - Fee-For-Service vs. Managed Care

The following graph shows the monthly enrollment in Medi-Cal for medical fee-for-service and managed care, from 1996 forward.

(Note: PCCM eligibles are included under managed care in this table.)



Tables 1.1B, Medi-Cal Eligibles by Program -Managed Care Programs

FFS-covered eligibles are excluded from this graph. Each type of managed care program is shown separately.

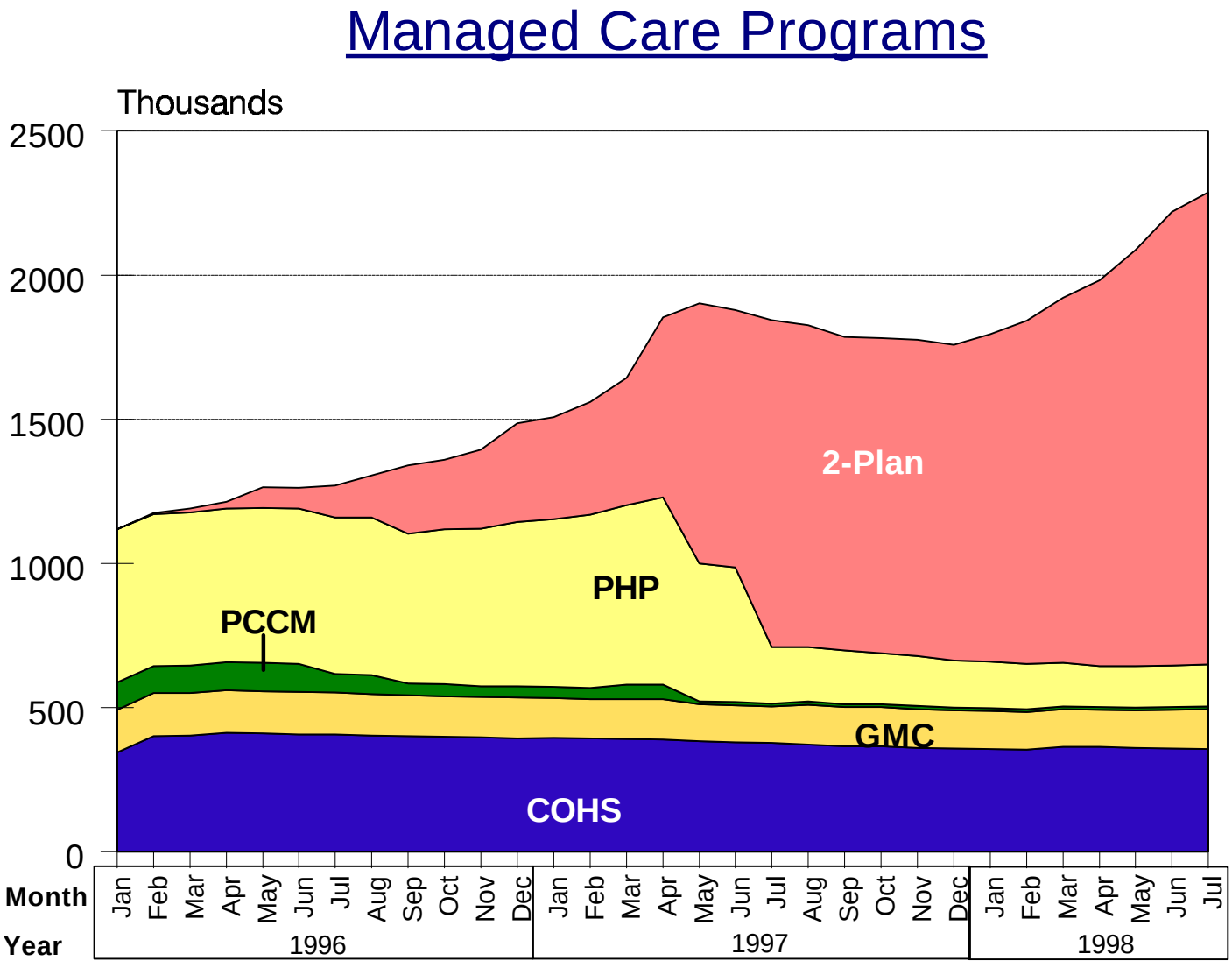


Table 1.2, Map of California's Managed Care Counties

The following map of California shows each county with either a managed care plan in operation or one scheduled to be implemented as of July 1998.

(Note: Excludes PHP and PCCM programs.)

Click here to view Table 1.2 Map.

Medi-Cal Managed Care Implementation

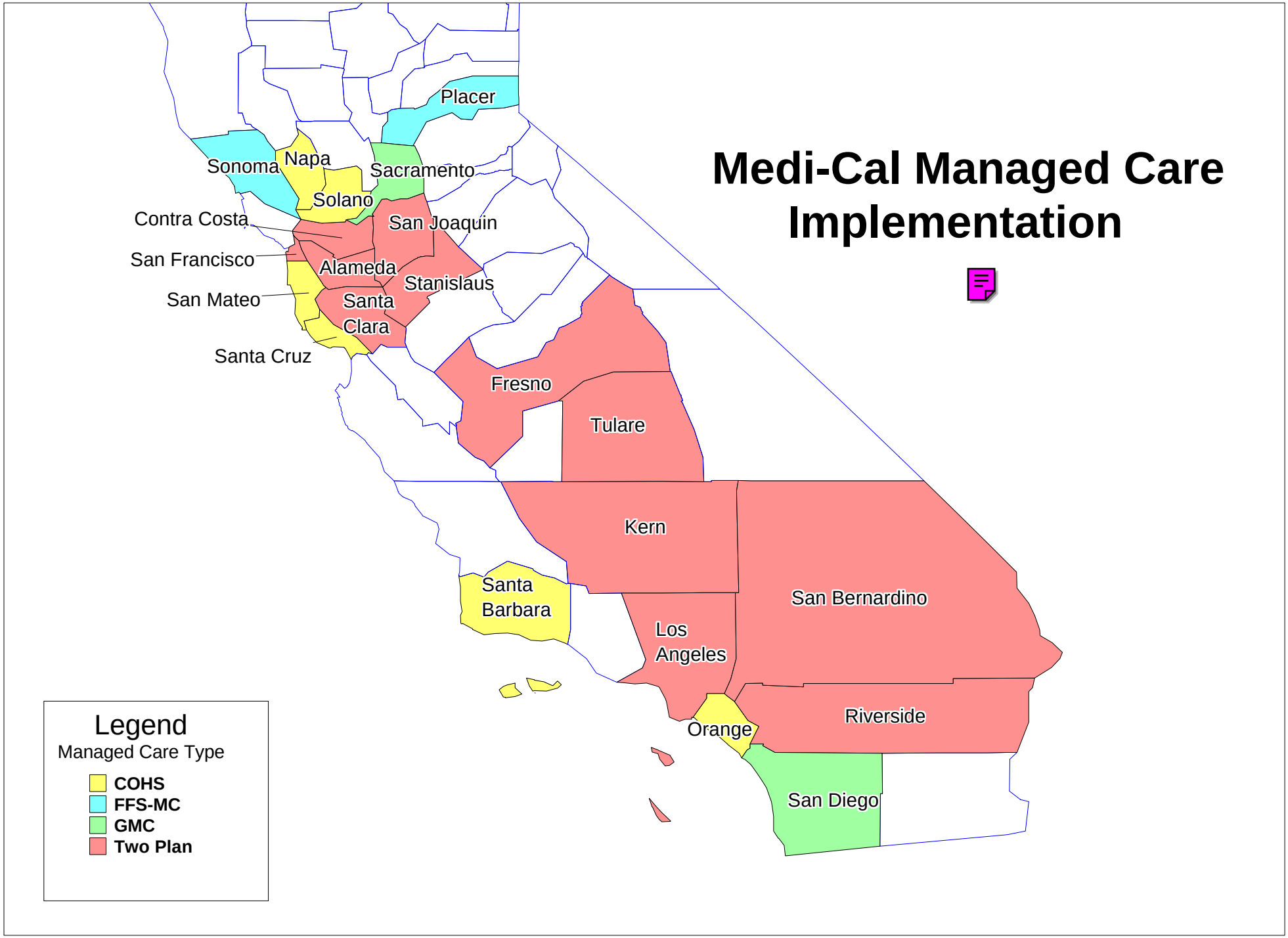


Table 1.3, Major Managed Care Plans, by County

The following table shows which Medi-Cal managed care plans are planned or are now operational by California county. The managed care programs covered are: County Organized Health Systems (COHS), Fee-For-Service Managed Care Network (FFS-MCN), Geographic Managed Care (GMC), and Two-Plan. Excluded are Prepaid Health Plan (PHP), Primary Care Case Management (PCCM), and special projects (e.g., AIDS, SCAN).

Click here to view Table 1.3

Table 1.3 Major Managed Care Plans by County

County	Program	LI/ CP	Plan Name	Start Date	Enrollment* as of Jul 98
Alameda	2-PLAN	LI	Alameda Alliance for Health	1/96	73,371
		CP	Blue Cross of California	7/96	25,724
Contra Costa	2-PLAN	LI	Health Net	2/97	41,382
		CP	Blue Cross of California	3/97	4,764
Fresno	2-PLAN	CP	Health Net	1/97	19,356
		CP	Blue Cross of California	11/96	101,453
Kern	2-PLAN	LI	Kern Health Systems	7/96	54,608
		CP	Blue Cross of California	9/96	26,779
Los	2-PLAN	LI	LA Care Health Plan	4/97	552,536
Angeles		CP	Health Net	7/97	349,361
Napa	COHS		Partnership Health Plan of Calif.	3/98	8,621
Orange	COHS		CalOptima	10/95	207,751
Placer	FFS/MCN		Placer County Managed Care Network	10/97	Contact Managed Care Division**
Riverside	2-PLAN	LI	Inland Empire Health Plan	9/96	58,569
		CP	Molina Medical Centers	2/98	8,282
Sacramento	GMC		various HMOs	4/94	154,571
San	2-PLAN	LI	Inland Empire Health Plan	9/96	77,876
Bernardino		CP	Molina Medical Centers	2/98	18,354
San Diego	GMC		various HMOs	8/98	not started
San	2-PLAN	LI	San Francisco Health Authority	1/97	21,398
Francisco		CP	Blue Cross of California	7/96	14,255
San	2-PLAN	LI	Health Plan of San Joaquin	2/96	56,958
Joaquin		CP	Omni HealthCare	2/97	13,382
San Mateo	COHS		Health Plan of San Mateo	12/87	39,833
Santa Barbara	COHS		Santa Barbara Health Initiative	9/83	35,893
Santa	2-PLAN	LI	Santa Clara Family Health Plan	2/97	40,071
Clara		CP	Blue Cross of California	10/96	30,357
Santa Cruz	COHS		Santa Cruz County Health Options	1/96	20,386
Solano	COHS		Solano Partnership Health Plan	5/94	42,532
Sonoma	FFS/MCN		Sonoma County Partners for Health Managed Care Network	3/97	Contact Managed Care Division **
Stanislaus	2-PLAN	LI	Blue Cross of California	10/97	24,486
		CP	Omni Health Care	2/97	22,842
Tulare	2-PLAN	LI	Blue Cross of California	3/99	N/A
		CP	Health Net	2/99	N/A

* Source for number of eligibles for all plans except FFS/MCN is the Monthly Medi-Cal Eligibility File.

** FFS/MCN eligible counts are available through the DHS/Medi-Cal Managed Care Division.

Table 1.4, Aid Category Groups by FFS and Managed Care – Sacramento GMC, Two-Plan, and COHS Counties

The following pie chart shows the distribution of Medi-Cal beneficiaries broken out by managed care enrollment vs. fee-for-service and mandatory vs. voluntary/other aid category group, for counties partially or fully implemented to managed care as of July 1998. (See Table 1.5 for a list of these counties.) As this indicates, the percent of those in managed care is 52.7% for all aid categories. When implementation is complete in these counties, the total percent in managed care will increase slightly. (See Appendix, Table A.1 for definitions of the aid category groupings.)

Source of these data is the July 1998 month of eligibility Medi-Cal Eligibles File using a four-month lag.

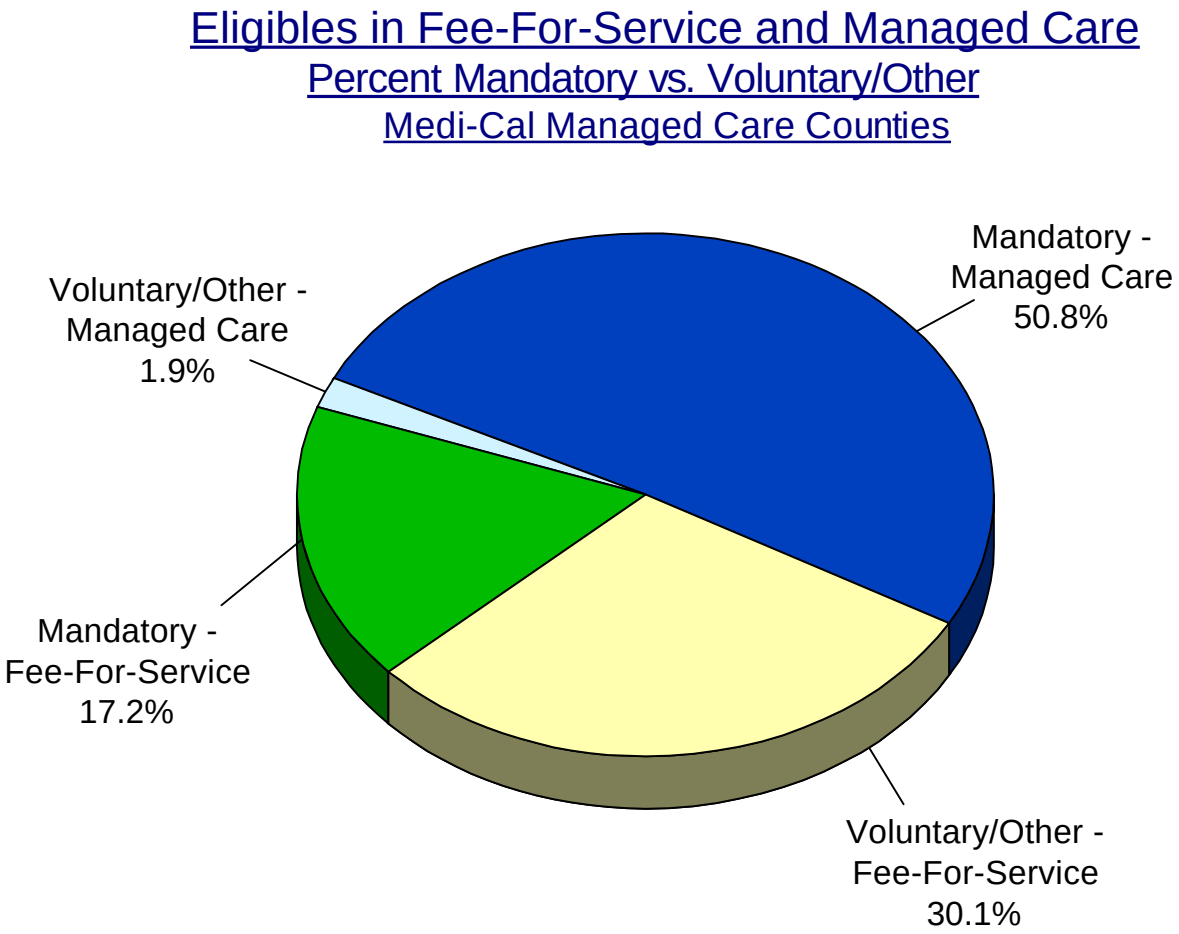
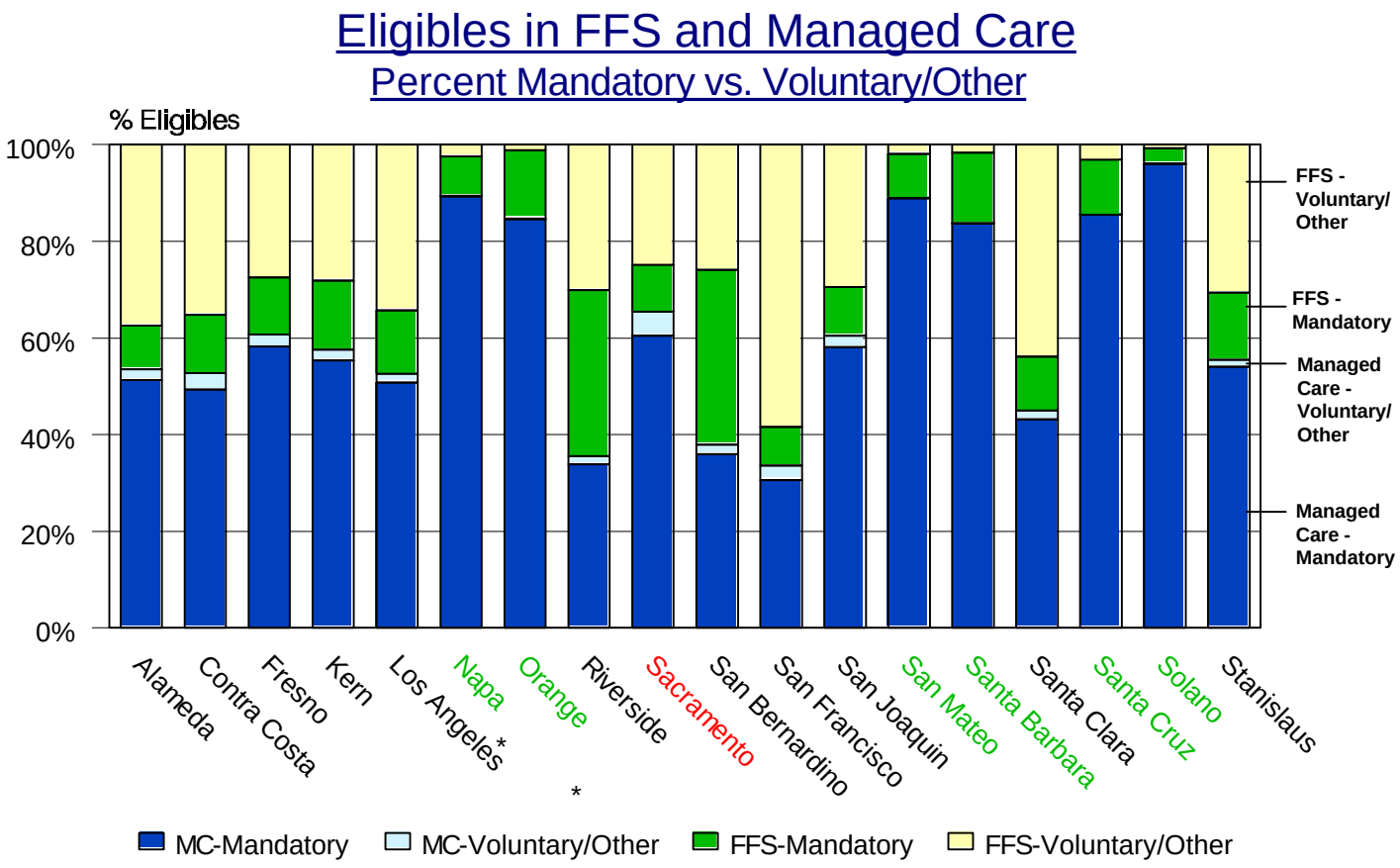


Table 1.5, Aid Category Groups by FFS and Managed Care – Sacramento GMC, Two-Plan, and COHS Counties

The following bar chart provides the distribution of Medi-Cal beneficiaries broken out by managed care enrollment vs. fee-for-service and mandatory vs. voluntary/other aid category group, for counties partially or fully implemented to managed care as of July 1998. As the chart shows over 50% of these beneficiaries are in managed care except in those counties still transitioning to managed care; the two exceptions are San Francisco and Santa Clara, which have a low overall proportion of mandatory aid code beneficiaries. Note also that in the COHS counties, 85 to 95% of the beneficiaries are in managed care. (San Diego and Tulare are not shown because transition to managed care had not begun as of July 1998.) (See Appendix, Table A.1 for definitions of the aid category groupings.)

Source of these data is the July 1998 month of eligibility Medi-Cal Eligibles File using a four-month lag.

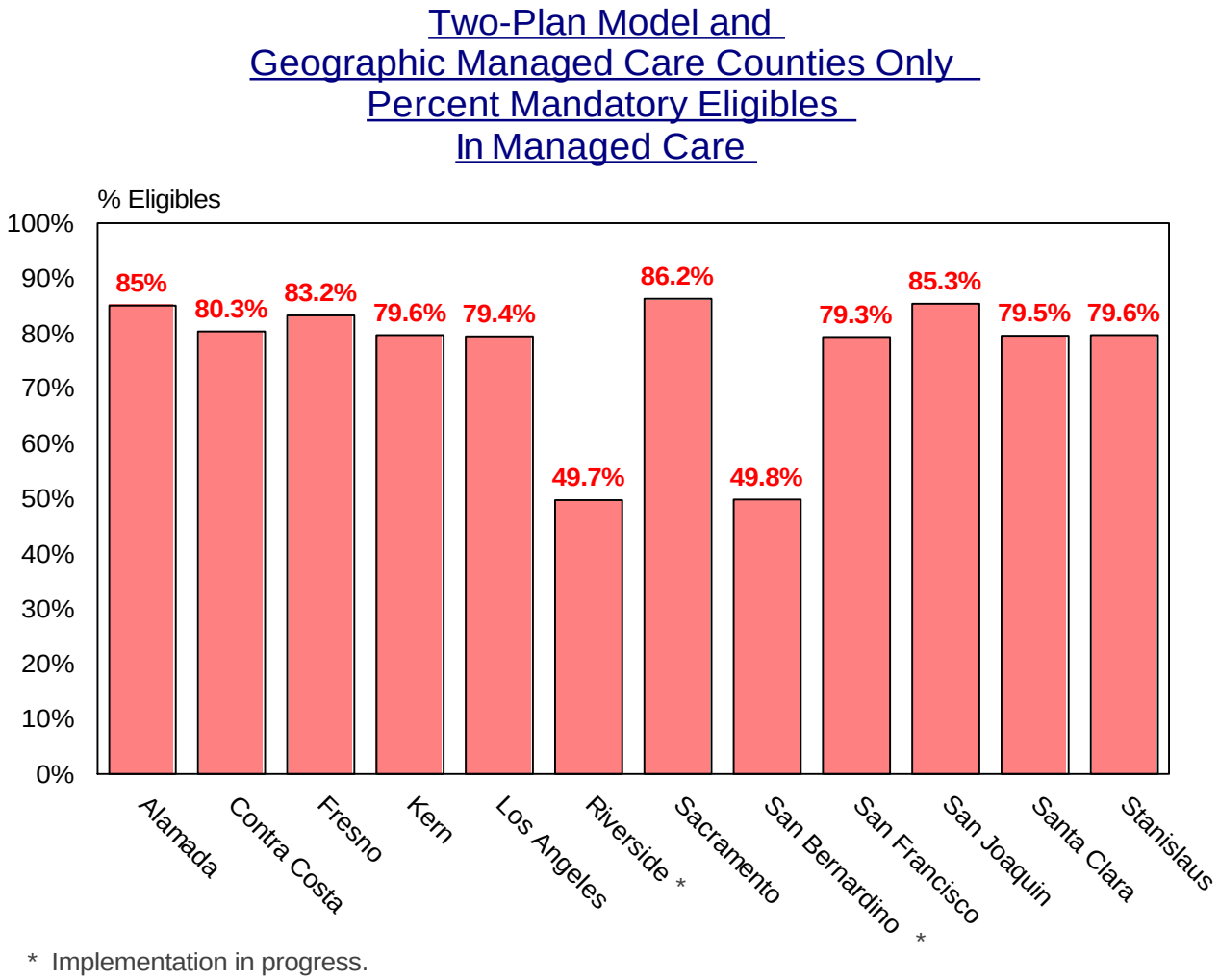


* Implementation in progress.
Two-Plan: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Solano, and Stanislaus counties.
COHS: Napa, Orange, San Mateo, Santa Barbara, Santa Clara, and Santa Cruz counties.
GMC: Sacramento county.

Table 1.6, Percent Mandatory Eligibles in Managed Care of All Mandatory Eligibles, Two-Plan Model Counties Only

Of those eligibles in a mandatory aid category, the following chart shows the percent of those actually enrolled in a managed care plan. (Note: Tulare is not shown because the Two-Plan Model was not yet implemented as of July 1998.) The month of eligibility for these data is July 1998 month of eligibility using a four month lag. (Note: Not all counties were fully implemented as of July 1998. See Table 1.3 for implementation dates by county.)

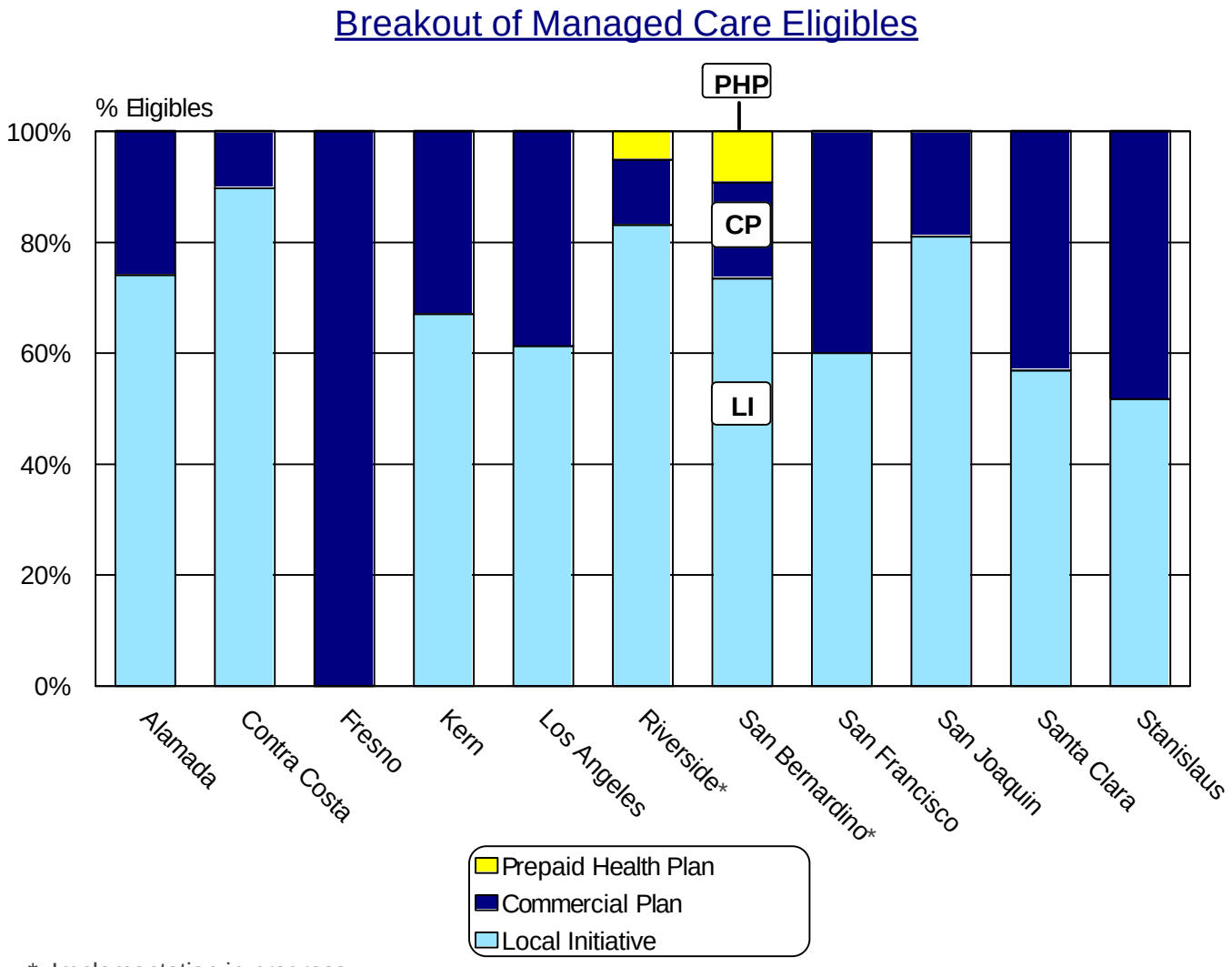
The percent of those in a mandatory aid category is always less than 100%. This is because, even though a beneficiary is in a mandatory aid category, they will not necessarily end up in a managed care plan. Reasons for this include: 1) managed care implementation is still in process; 2) the beneficiary received Medi-Cal eligibility retroactively (that is, between the start of the eligibility month and up to four months later); 3) the beneficiary has other health coverage (usually, CHAMPUS, Medicare HMO, Kaiser, or some PHP/HMO and EPO coverage) that excludes them from enrolling in a plan; 4) the beneficiary just became eligible for Medi-Cal in a particular county, and is still in the process of selecting a plan or will be defaulted into one; 5) the beneficiary lives in an exempted zip code; 6) the beneficiary has a medical exemption granted by the DHS. For a complete list of these exemptions, contact the DHS Medi-Cal Managed Care Division.



* Implementation in progress.

Table 1.7, Breakout of Managed Care Eligibles by Program and County, Two-Plan Model Counties Only

The following chart shows a distribution of the Medi-Cal Managed Care population by managed care program, effective with the July 1998 month of eligibility, using a four month lag. (Note: Tulare is not shown because the Two-Plan Model was not yet implemented as of July 1998. In addition, since the five COHS counties only have the one program of managed care, these counties are also not shown here.)



* Implementation in progress.

Section 2, Demographic Characteristics

The beneficiaries in the aid categories considered mandatory under the Two-Plan Model have a different demographic profile than the non-mandatory beneficiaries. This former group, which includes the AFDC and AFDC-linked aid categories, would, under most circumstances, have to join a managed care plan within a COHS, GMC, or Two-Plan Model county. The following tables contrast the demographic characteristics of the AFDC population with those of the "voluntary" and "other" groups for all Medi-Cal eligibles (managed care and fee-for-service). (See Appendix, Table A.1 for definitions of Two-Plan Model mandatory, voluntary, and "other" categories.)

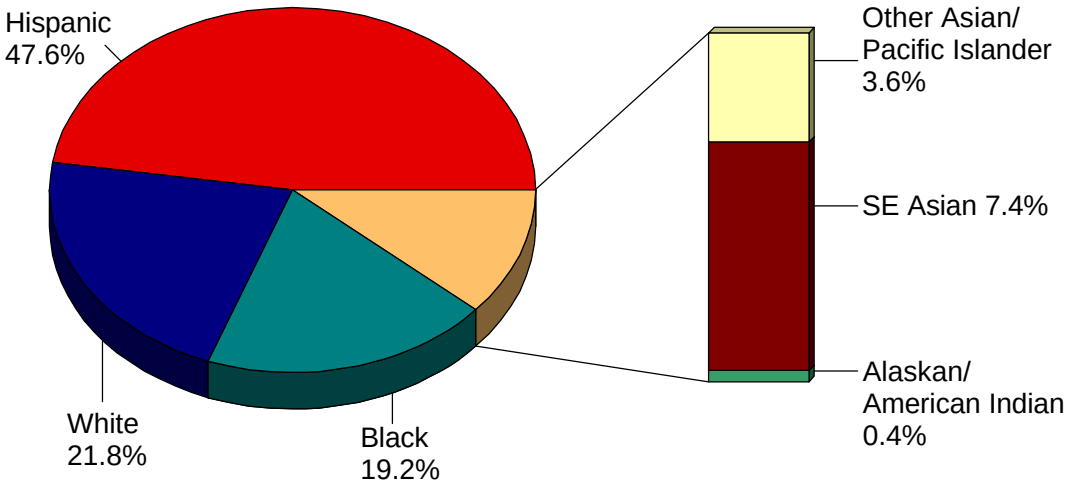
(Note: Since the non-mandatory population for the Two-Plan Model counties -- which includes predominately the SSI population -- has a relatively high percent of blank values for ethnicity and language, such records were ignored in determining the percentages shown on the following two pages. This was done assuming this population has a composition similar to those with valid values.)

Table 2.1, Breakout of Eligibles by Major Ethnic Groups

The following charts show a distribution of the Medi-Cal eligible population in managed care (GMC and Two-Plan) counties by major ethnic category. The first chart shows this breakout for the population considered Mandatory under the Two-Plan model, that is, primarily AFDC-Cash Grant. The second chart covers those not in a Sacramento GMC or Two-Plan Mandatory aid category group.

Source of these data is the July 1998 month of eligibility Medi-Cal Eligibles File using a four-month lag.

Mandatory Eligibles



Non-Mandatory Eligibles

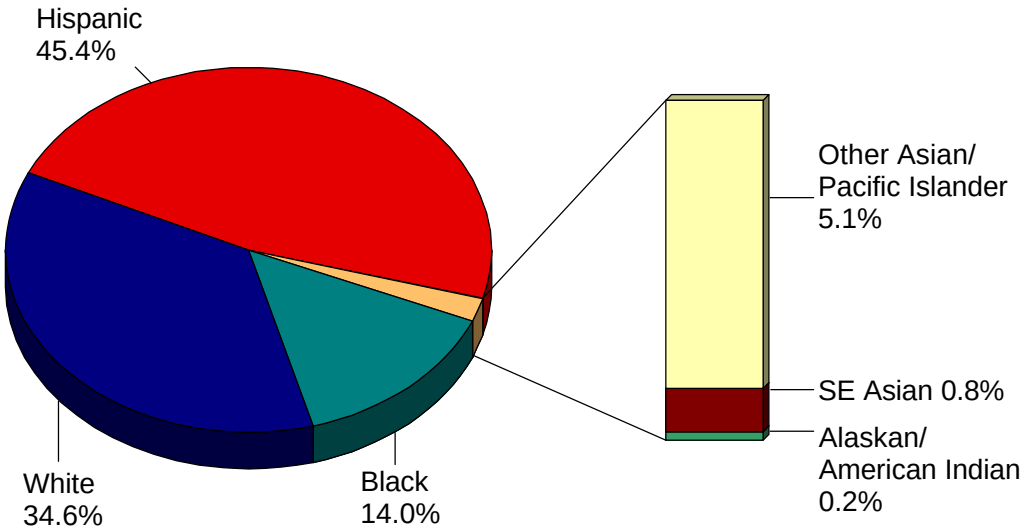
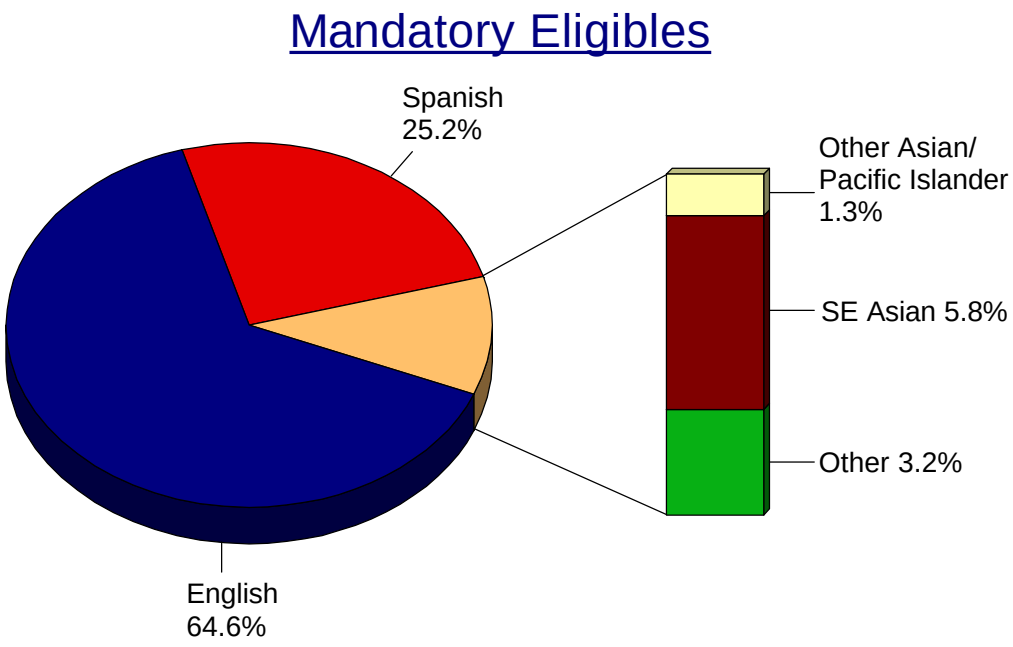


Table 2.2, Breakout of Eligibles by Major Language Category

The following charts show a distribution of the Medi-Cal eligible population in managed care (GMC and Two-Plan) counties by major language category. The first chart shows this breakout for the population considered Mandatory under the Two-Plan model, that is, primarily AFDC-Cash Grant. The second chart covers those not in a Sacramento GMC or Two-Plan Mandatory aid category group.

Source of these data is the July 1998 month of eligibility Medi-Cal Eligibles File using a four-month lag.



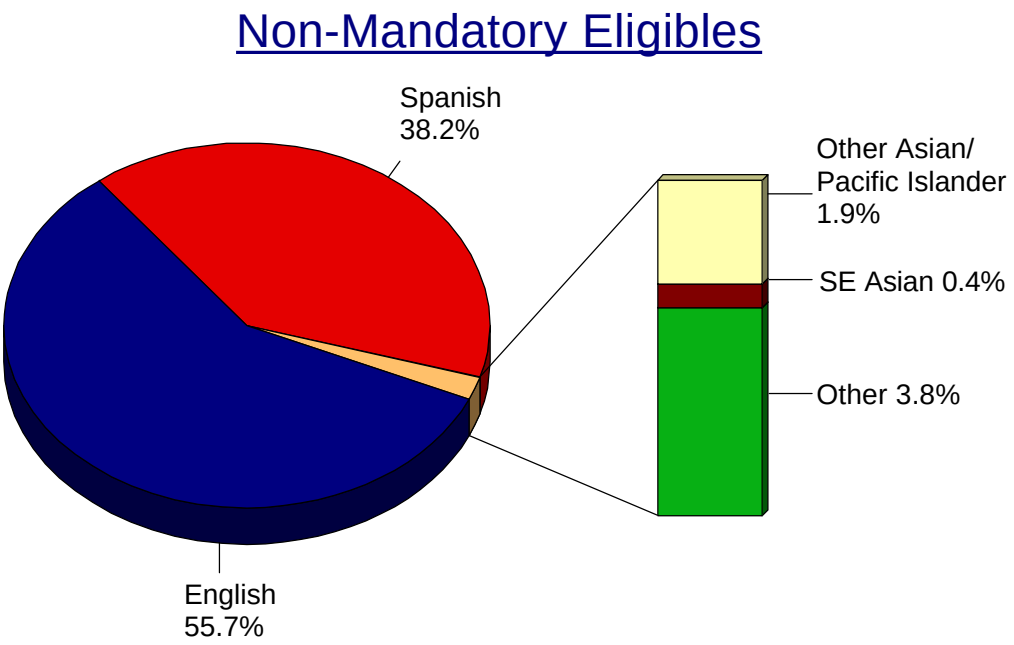


Table 2.3, Breakout of Eligibles by Age, Gender, and Aid Category Groups

Those in managed care are predominately those on AFDC and, as such, have certain age and gender characteristics distinguishing them as a group from those in the groups designated as voluntary and "other" within the Two-Plan Model counties. (See Section 1.2 of the Managed Care Annual Statistical Report published in March 1998 for an explanation of "mandatory," "voluntary," and "other.") (See Appendix, Table A.1 for definitions of Two-Plan Model mandatory, voluntary, and "other" categories.)

Note: The area shown for each gender represents the **total** number of eligibles. For example, in the graph below for the mandatory aid category population, the total number of female eligibles "4 and under" is 362,000, whereas the number of males "4 and under" is 374,000. The **total** number of eligibles (top edge of the area represented by the Male variable) for "4 and under" is thus 736,000. By the same token, the number of females in the "20-24 yrs" category is 141,150, the number of males in this category is 26,250, and the total is 167,400.

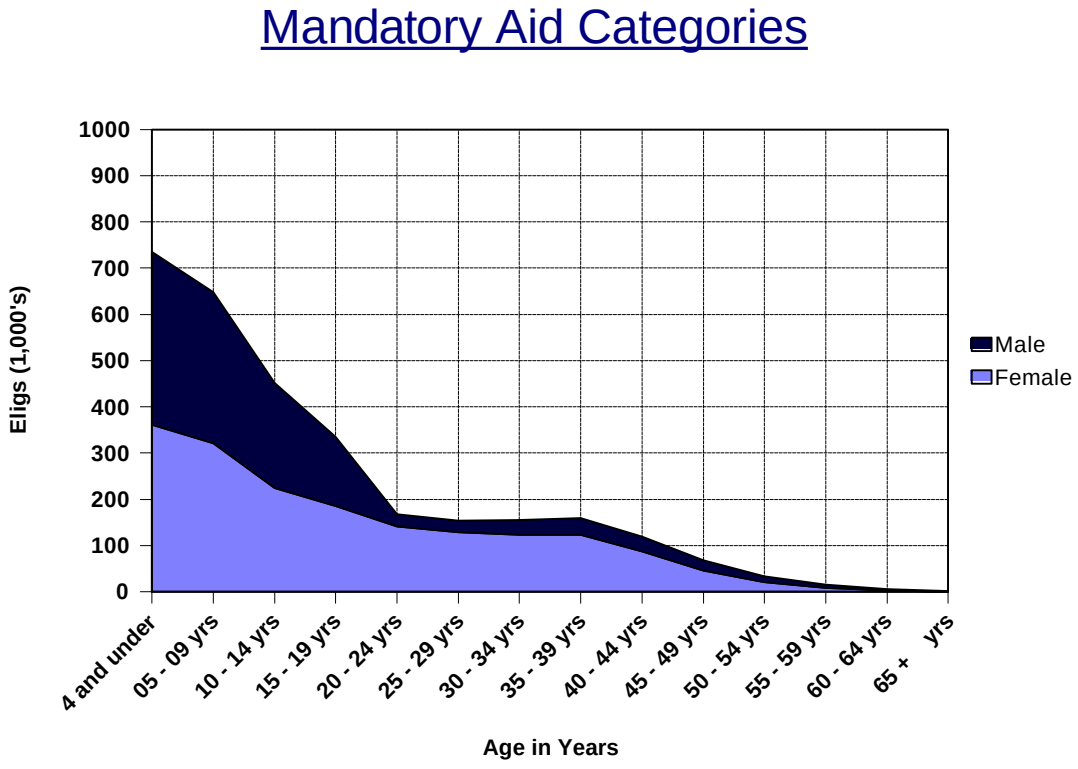
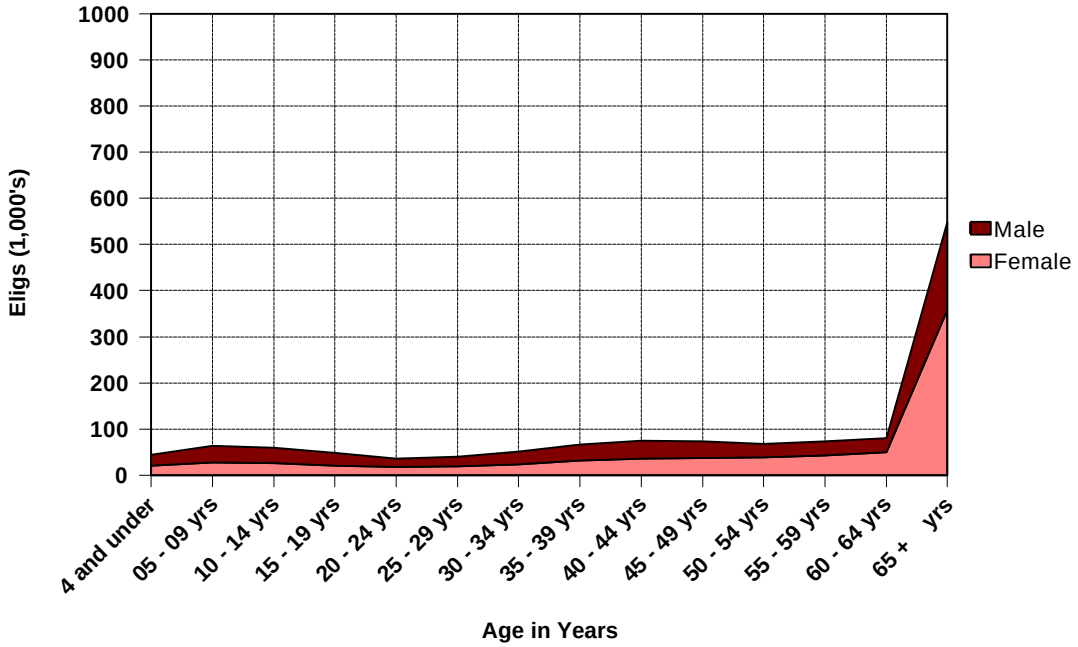
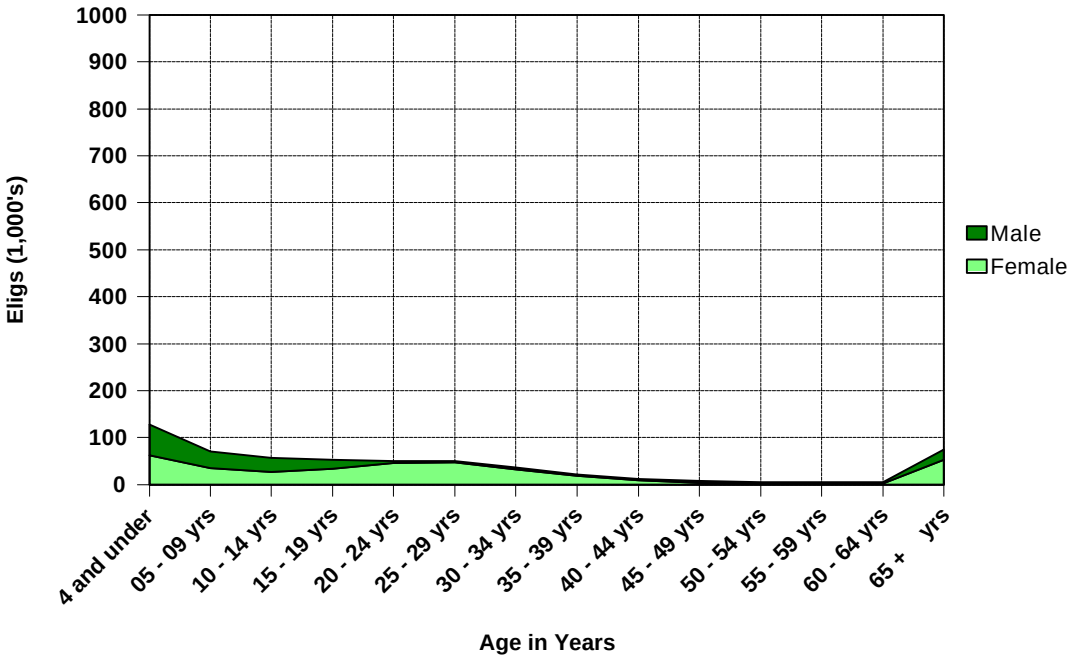


Table 2.3, Breakout of Eligibles by Age, Gender, and Aid Category Groups (continued)

Voluntary Aid Categories



Other Aid Categories



Section 3, Eligibility Continuity and Rate of New Eligibles

The length of time someone is on Medi-Cal is an important factor in the provision of medical services under managed care. The longer and more continuously a person is enrolled in a managed care plan, the easier it should be for a beneficiary to receive preventive and continuous care. Other benefits include the development of a closer relationship between the primary care physician and the beneficiary, and less administrative cost to the plan. One way to measure duration of eligibility is to determine how long individual beneficiaries are continuously Medi-Cal eligible. Tables 3.1 and 3.2 provide rates of continuous eligibility for a recent period of time, without regard to a person's pre-existing eligibility. Table 3.3 provides a continuous eligibility rate for those most likely to belong to a Medi-Cal managed care plan, the AFDC-Cash Grant beneficiaries, after at least one month of Medi-Cal ineligibility (a "new" beneficiary) vs. those who may or may not have been eligible the prior period.

This "continuity of eligibility" methodology was then applied to the mandatory aid category population for those counties that had implemented GMC and Two-Plan managed care plans. Separate rates were developed for all of those eligibles who remained enrolled in a managed care plan, these rates are shown in Table 3.4.

Another useful measure of the stability of the Medi-Cal population in terms of eligibility is the rate at which new eligibles get on Medi-Cal. One measure of this is to determine the number of eligibles moving from ineligibility to eligibility status, and to express this as a percent of all eligibles. This rate was derived for all eligibles as well as just the managed care mandatory aid category population, and is depicted in Tables 3.5 and 3.6.

Note: The information used to construct Tables 3.1 through 3.3 were derived from a longitudinal data base for a five percent sample of all Medi-Cal beneficiaries. The period represented is January 1995 through December 1997 (shown on the tables as Month 00 and Month 36, respectively).

Table 3.1, Continuity of Eligibility in Aggregate

The following chart shows how long a beneficiary would tend to remain eligible for Medi-Cal over a three year period. Recent federal and State legislation as well as an improved economy will continue to have an impact on the rate at which persons stay eligible for Medi-Cal. This chart reflects eligibility trends only as they existed during the CY95 through CY97 period.

To establish the rates shown below, each beneficiary in our database was tracked for thirty-six months, regardless of their eligibility status in the month immediately preceding the period. Any break in eligibility would drop an eligible from the curve at that point. (Studies have shown only a slight difference in the percent continuously eligible when a one month break is allowed in the definition.)

The curve labeled "Aggregate" shows the rate at which a person who was eligible for Medi-Cal in the first month is likely to remain on Medi-Cal each month for up to thirty-six months. The chart shows that 73% of this population will likely still be on Medi-Cal after the first year, 59% after two years, and 48% after three. (Note that this is a drop of 1.6%, 0.3%, and 1.6% for the span CY94-96 reported in last year's report.) If this population were subsumed into eight relatively homogenous (in terms of eligibility) groups, the rate of continuous eligibility for all these beneficiaries staying within their assigned group is shown in the chart as "Aggregate - All Groups." (The difference between the curves is the population who were continuously eligible, but went from one eligibility group to another.)

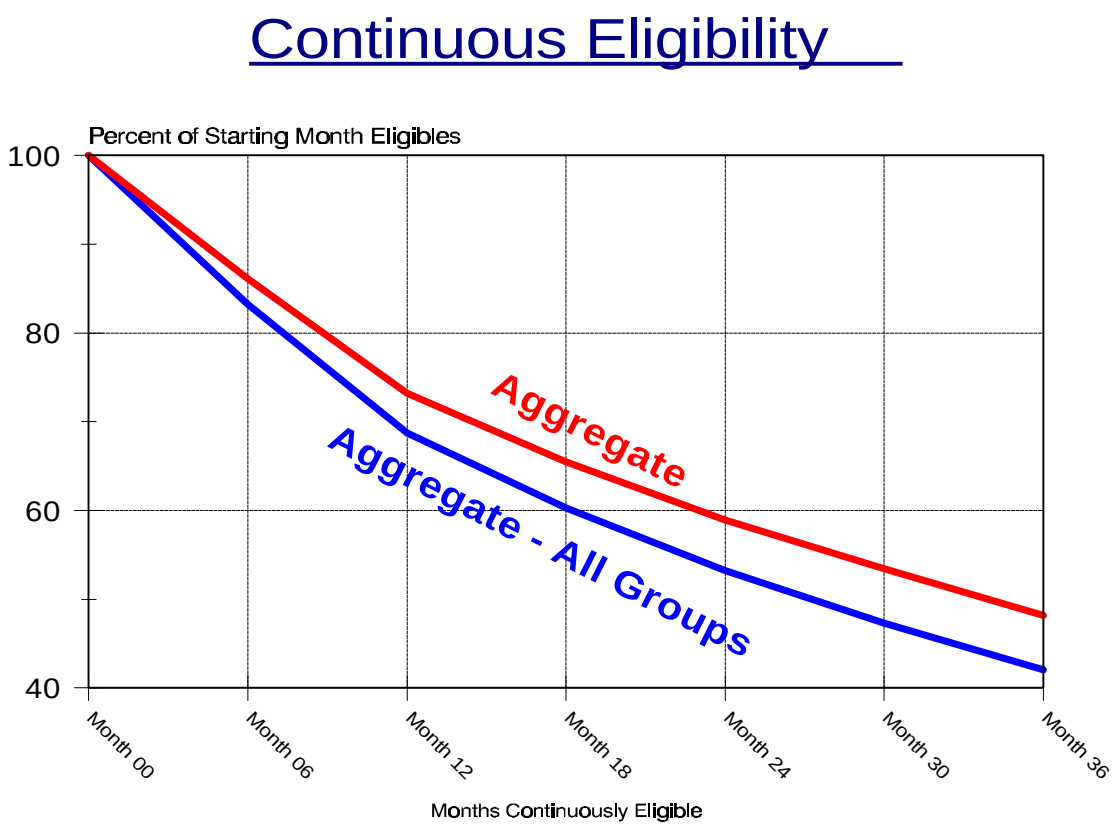


Table 3.2, Continuity of Eligibility by Major Aid Category Group

The following chart is similar to Table 3.1, except that eligibles were subsumed into distinct eligibility groups. Each curve represents those eligibles who belong to an assigned group for the months shown. If a Medi-Cal eligible either ceases being eligible, or "jumps" to one of the other seven groups, they are excluded from the curve at that point.

The eight major groups shown in the chart are: 1. SSI/SSP; 2. Long Term Care; 3. AFDC - Cash Grant; 4. Medi-Cal only, Families; 5. Medi-Cal only, Aged, Blind, Disabled, no share of cost; 6. Share of cost; 7. OBRA; 8. Miscellaneous. (For a listing of the aid categories making up each of these groupings, refer to the Appendix, Table A.2.)

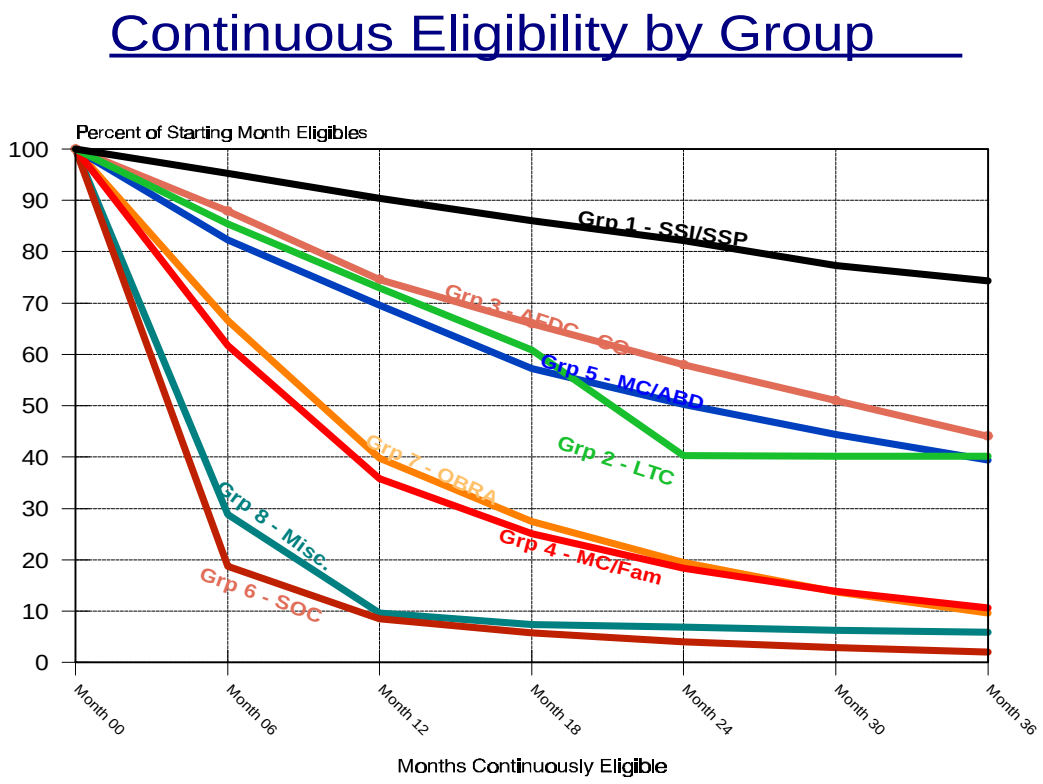


Table 3.3, Continuity of Eligibility for AFDC - Cash Grant -- New Eligibles

Tables 3.1 and 3.2 show continuous eligibility rates for Medi-Cal eligibles for a three year period without regard to their prior eligibility status. It may also be of interest to know the rate of continuous eligibility for those who were ineligible for at least one month immediately prior to the three year study period. The following chart shows two rates of continuous eligibility for AFDC - Cash Grant eligibles (those most likely to go into managed care): 1) "ALL" -- the continuous eligibility rate for AFDC - CG (see Table 3.2); 2) "NEW" -- the rate of eligibility for the subset population which was not on Medi-Cal during the month before Month 00.

As indicated, the attrition **rate** for the NEW eligibles group declines quicker than for the ALL eligibles group, especially for months 06 through 12. One explanation for this may be that many persons who first become eligible for Medi-Cal only stay on Medi-Cal for a short period. As the duration of the Medi-Cal eligibility period increases, however, the attrition rate more closely resembles the one for those on Medi-Cal for longer periods.

Note that the ALL eligibles percent is higher than that for the NEW eligibles for each month. This is due to the fact that the ALL curve includes not only the NEW eligibles, but also those who have been on Medi-Cal for one, two, etc. months at Month 00.

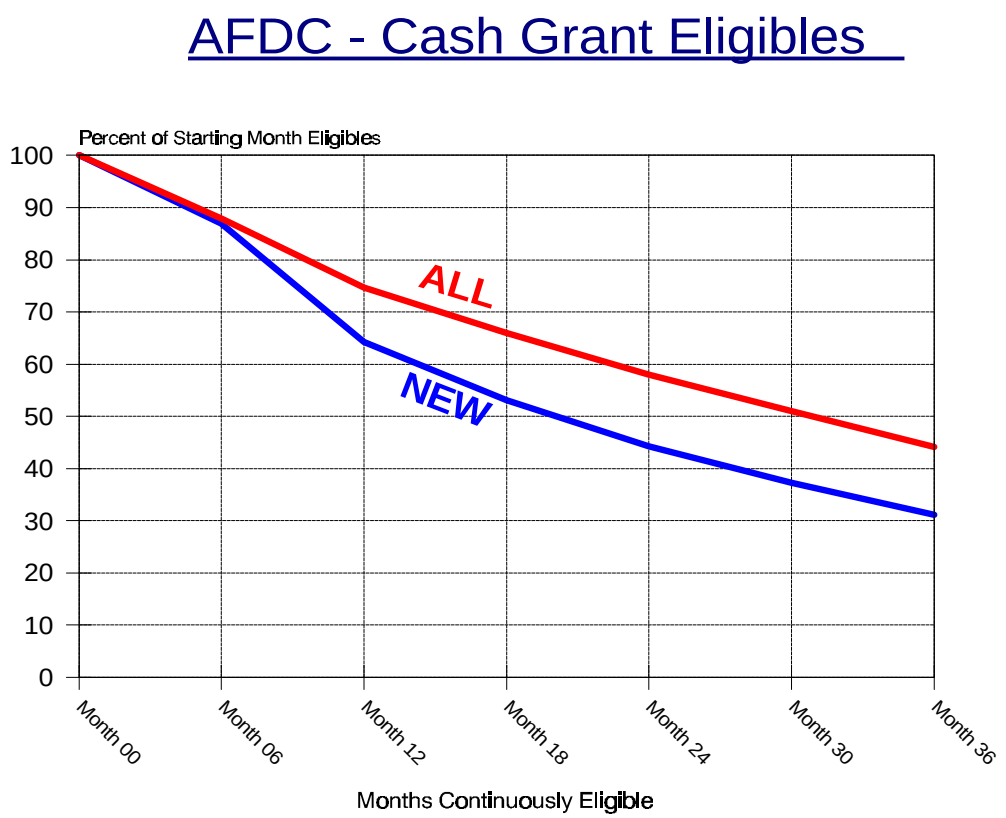


Table 3.4, Continuity of Eligibility for Mandatory Aid Codes, Eligible vs. Enrolled in a Plan

The rate at which persons on Medi-Cal will be continuously eligible will be somewhat higher than for the population enrolled in a managed care plan. The difference in the rates may be attributable to such reasons as switching enrollment from one plan to another or obtaining a medical exemption to obtain services under fee-for-service. The following chart shows these rates for the period July 97 through December 97 for GMC and Two-Plan counties fully implemented (see the supporting Excel table for the plan numbers included). The methodology applied here is similar to that used in Table 3.2 above; the rate is for a population of eligibles who may or may not have been eligible prior to July 97.

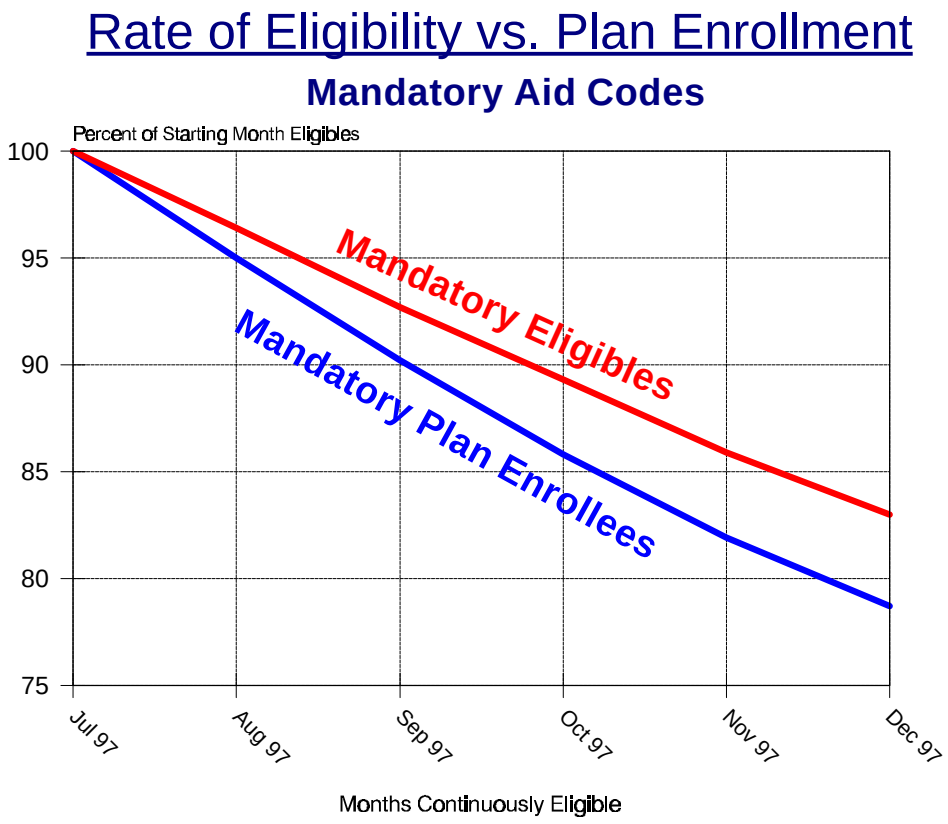


Table 3.5, Rate of "Six-Month" New Beneficiaries on Medi-Cal

As with continuity of eligibility, the rate at which beneficiaries become eligible for Medi-Cal provides some measure of the turnover of this population. As mentioned above, this in turn can have a direct impact on the quality of care provided under managed care. There are two approaches to looking at this turnover issue: one is to consider just those who are relatively new to Medi-Cal, the other is to look at those with only one month of ineligibility. The difference should be an approximation of those intermittently (i.e., not continuously) enrolled in Medi-Cal.

The following chart shows the rate at which beneficiaries become eligible after being ineligible (not on Medi-Cal) for six months, i.e., the "new to Medi-Cal" population. The percentages shown in this table were derived by first calculating a denominator of a count of eligibles for the months February, May, August, and November for the calendar years 1995 through 1997. A subset of this population, those ineligible the previous six months, was used to calculate a percent or rate of those "new" to Medi-Cal each month. The same methodology was used to develop a rate for the eligibles most likely to be in a managed care plan in Two-Plan Model and GMC counties.

As information from this chart shows, the overall rate of new persons coming onto Medi-Cal has dropped significantly since CY93. The chart also indicates that the rate at which the mandatory aid category eligibles (primarily AFDC - CG) are becoming eligible is less than the All Eligibles rate, though this disparity narrowed by CY96. One explanation for this sharp drop in new eligibles may be that, of those to eventually be affected by the economic recession, most by CY93 had already been affected in terms of having to go on Medi-Cal. Of course, the AFDC-CG eligible population is most sensitive to changes in the jobless rate, and thus the drop in their rate is faster.

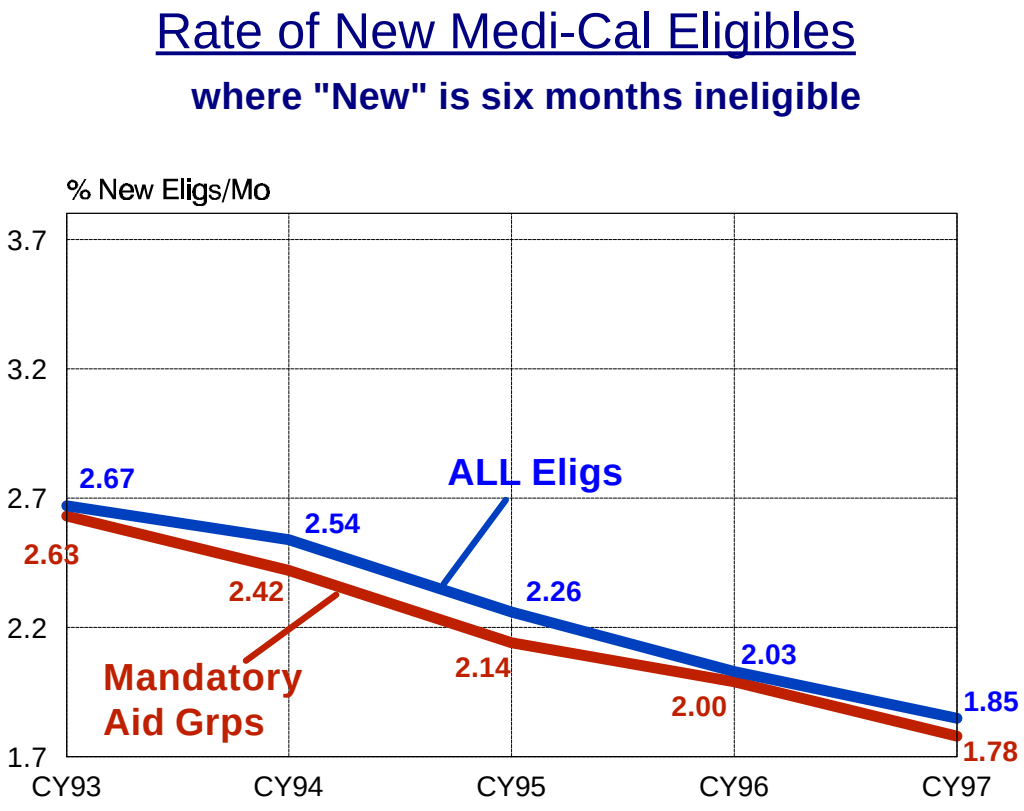
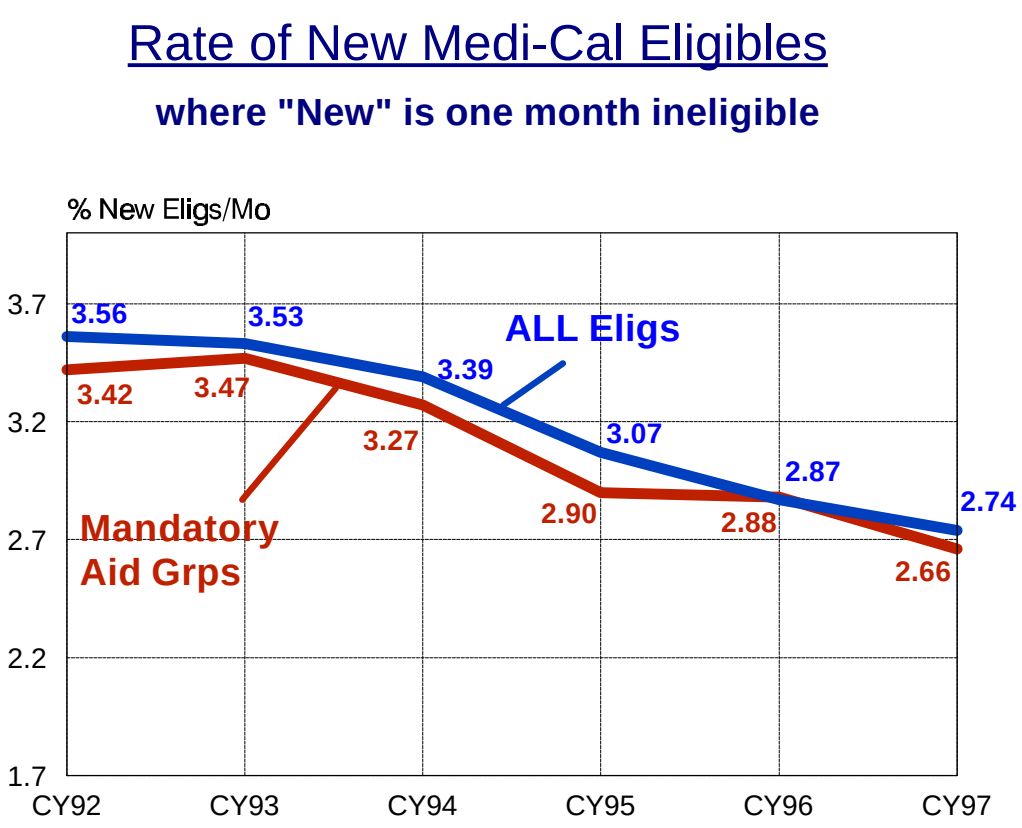


Table 3.6, Rate of "One-Month" New Beneficiaries on Medi-Cal

As the following chart indicates, when the definition of "new eligible" is relaxed from six months of ineligibility to one month, the percentages increase substantially: the average (not depicted here) for the years CY93 through CY97 for the All Eligibles population increased from 2.27% to 3.12%; the respective rate for the Mandatory Aid Group population increased from 2.19% to 3.04%. (The proportion of the six-month new population to the one-month new population is about the same between the two groups.) In comparing the two charts, it appears that the proportion of intermittent eligibles stays about the same throughout the period CY93 through CY97.



Appendices

Appendix, Table A.1, List of Aid Categories by Managed Care Model and Type of Membership Status

The following table provides a list by aid categories, and which are considered mandatory (M), vs. voluntary (V), vs. other (o) (can't join) for each plan model. (Note: This table was current as of July 1998. For a current table, contact the DHS Medi-Cal Managed Care Division.)

	COHS				GMC	Two-Plan	PHP/ PCCM
Aid Cat.	**Napa**	**Orange**	**San Mateo & Solano**	**Santa Barbara & Santa Cruz**	**Sacramento**		
01	M	M	M	M	V	M	V
02	M	M	M	M	V	M	V
03	M	M	M	M	V	V	V
04	M	M	M	M	V	V	V
08	M	M	M	M	V	M	V
0A	M	M	M	M	V	M	V
10	M	M	M	M	V	V	V
13	M	M	M	M	o	o	o
14	M	M	M	M	V	V	V
16	M	M	M	M	V	V	V
17	M	M	M	M	o	o	o
18	M	M	M	M	V	V	V
20	M	M	M	M	V	V	V
23	M	M	M	M	o	o	o
24	M	M	M	M	V	V	V
26	M	M	M	M	V	V	V
27	M	M	M	M	o	o	o
28	M	M	M	M	V	V	V
30	M	M	M	M	M	M	V
32	M	M	M	M	M	M	V
33	M	M	M	M	M	M	V
34	M	M	M	M	M	M	V
35	M	M	M	M	M	M	V
36	o	M	M	M	V	V	V
37	M	M	M	M	o	o	o
38	M	M	M	M	M	M	V
39	M	M	M	M	M	M	V
3A	M	M	M	M	M	M	V
3C	M	M	M	M	M	M	V
3G	M	M	M	M	M	M	V
3H	M	M	M	M	M	M	V
3P	M	M	M	M	M	M	V
3R	M	M	M	M	M	M	V
40	M	M	M	M	V	V	V
42	M	M	M	M	V	V	V
45	M	M	M	M	M	M	V
4C	M	M	M	M	V	V	V
4K	M	M	M	M	V	V	V

Appendix, Table A.1, List of Aid Categories by Managed Care Model and Type of Membership Status (continued)

	COHS				GMC	Two-Plan	PHP/ PCCM
Aid Cat.	**Napa**	**Orange**	**San Mateo & Solano**	**Santa Barbara & Santa Cruz**	**Sacramento**		
53	M	o	M	M	o	o	o
54	M	M	M	M	M	M	V
55	M	o	M	o	o	o	o
58	M	o	M	o	o	o	o
59	M	M	M	M	M	M	V
5F	M	o	M	o	o	o	o
5G	M	o	M	o	o	o	o
5K	M	M	M	M	V	V	V
5N	M	o	M	o	o	o	o
60	M	M	M	M	V	V	V
63	M	M	M	M	o	o	o
64	M	M	M	M	V	V	V
65	M	M	M	M	o	o	o
66	M	M	M	M	V	V	V
67	M	M	M	M	o	o	o
68	M	M	M	M	V	V	V
6A	M	M	M	M	V	V	V
6C	M	M	M	M	V	V	V
81	M	M	M	M	o	o	o
82	M	M	M	M	M	M	V
83	M	M	M	M	o	o	o
86	M	M	M	M	V	V	V
87	M	M	M	M	o	o	o

Appendix, Table A.2, List of Aid Categories Used For Section 3

Major Grouping		Minor Grouping	Aid Categories
Elig Study	CIDCUM		
1. SSI/SSP	CASH GRANT	AB	20, 22
1. SSI/SSP	CASH GRANT	ATD	60, 62
1. SSI/SSP	CASH GRANT	OAS	10, 12
1. SSI/SSP	IN HOME SUPPORT	AB	28
1. SSI/SSP	IN HOME SUPPORT	ATD	68
1. SSI/SSP	IN HOME SUPPORT	OAS	18
2. LTC	MI ADULT	------	53
2. LTC	MN-LONG TERM NG	AB	23
2. LTC	MN-LONG TERM NG	ATD	63
2. LTC	MN-LONG TERM NG	OAS	13
3. AFDC-CG	CASH GRANT	AFDC	06, 30, 32, 33, 35, 38, 40, 42, 43
3. AFDC-CG	CASH GRANT	AFDC	77, 78, 3A, 3C, 3P, 3R, 3G, 3H, 3E, 3L, 3M, 3U, 4C
4. M/C only, Families, No SOC	TRANSITIONAL	AFDC	39, 54, 59
4. M/C only, Families, No SOC	CHILDREN	------	72, 74, 7A, 7C, 5M
4. M/C only, Families, No SOC	INFANTS	------	07, 47, 69, 79
4. M/C only, Families, No SOC	MI ADULT	------	86
4. M/C only, Families, No SOC	MI YOUTH	------	45
4. M/C only, Families, No SOC	MI YOUTH	------	4K
4. M/C only, Families, No SOC	MI YOUTH	------	04
4. M/C only, Families, No SOC	MI YOUTH	------	5K
4. M/C only, Families, No SOC	MI YOUTH	------	03
4. M/C only, Families, No SOC	MI YOUTH	------	82
4. M/C only, Families, No SOC	MINOR CONSENT	------	7M, 7P, 7R, 7N
4. M/C only, Families, No SOC	MN - NO SOC	AFDC	34, 3N
4. M/C only, Families, No SOC	WOMEN	------	44, 48, 49, 70, 75, 76, 7F, 7G
5. M/C only, ABD, No SOC	MN - NO SOC	AB	24
5. M/C only, ABD, No SOC	MN - NO SOC	ATD	64
5. M/C only, ABD, No SOC	MN - NO SOC	OAS	14
5. M/C only, ABD, No SOC	TITLE II DISRGRD	AB	25, 26, 6A
5. M/C only, ABD, No SOC	TITLE II DISRGRD	AFDC	46
5. M/C only, ABD, No SOC	TITLE II DISRGRD	ATD	36, 66, 6C
5. M/C only, ABD, No SOC	TITLE II DISRGRD	OAS	15, 16
6. SOC	MI ADULT	------	87
6. SOC	MI YOUTH	------	83
6. SOC	MN - SHR OF COST	AB	27
6. SOC	MN - SHR OF COST	AFDC	37
6. SOC	MN - SHR OF COST	ATD	65, 67
6. SOC	MN - SHR OF COST	OAS	17
7. OBRA	OBRA ALIENS	------	55, 58, 5F, 5G, 5H
8. Miscellaneous	ICRA ALIENS	------	51, 52, 56, 57
8. Miscellaneous	MI ADULT	------	81
8. Miscellaneous	PARENTERAL NUTRI	------	73
8. Miscellaneous	QMB-ONLY	------	80, 8G
8. Miscellaneous	REFUGEES	------	01, 0A, 02, 08
8. Miscellaneous	RENAL DIALYSIS	------	71
8. Miscellaneous	TB PROGRAM	------	7H